

Dayton Eye Surgery Center

81 Sylvania Drive Dayton, OH 45440

Phone: (937) 431-9531

Fax: (937)431-9532 or (937) 886-7062

Report of History & Physical

(Must be dated within 60 days of surgery date and faxed to the number above)

Patient: _____

Surgery Date: _____

Date of Birth: _____

Surgeon: _____

Procedure: _____

Anesthesia: _____

DATE OF HISTORY & PHYSICAL:

PHYSICAL EXAMINATION:

	Y	N
CARDIAC DISEASE:		
CHF <input type="checkbox"/> Echo EF%		
Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/>		
MI within last 3 months		
Old MI <input type="checkbox"/> CAD <input type="checkbox"/>		
Arrhythmia <input type="checkbox"/> AFib <input type="checkbox"/>		
Heart Murmur <input type="checkbox"/> Valvular Disease <input type="checkbox"/>		
Hypertension		
Peripheral Vascular Disease		
LUNG DISEASE:		
Asthma <input type="checkbox"/> Home Oxygen <input type="checkbox"/>		
Emphysema <input type="checkbox"/> COPD <input type="checkbox"/>		
Smoker		
Sleep Apnea <input type="checkbox"/> CPAP <input type="checkbox"/>		
NEUROLOGICAL:		
CVA		
Carotid Bruit R <input type="checkbox"/> L <input type="checkbox"/>		
Seizure Disorder		
Neuro/Psych		
ENT		
Thyroid		
Liver Disease		
Hiatal Hernia		
Diabetes type 1 <input type="checkbox"/> type 2 <input type="checkbox"/>		
Kidney Disease		
Musculo-Skeletal		
Hematological Disorders		
Other Diseases/Conditions		
Presence of Bed Bugs/Parasite		

Temp: _____ BP: _____ P: _____
 Height: _____ Weight: _____

	Normal	Abnormal
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

 ALLERGIES None (If needed, list on separate page)

- Reaction
- Latex _____
 - Adhesive Tape _____
 - Lidocaine _____
 - Sulfa _____
 - Topical Iodine _____

CURRENT MEDICATIONS & DOSAGES:
 (If needed, list on separate page)

Does patient have MRSA, history of MRSA, or other active infection? _____

Does the patient take a GLP-1 Agonist ? _____

<input type="checkbox"/> For Diabetes	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly
<input type="checkbox"/> For weight loss	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly

Previous Surgery _____

Anesthetic Complications _____

Examining Physician Signature _____

Examining Physician Name -Print _____

Date: _____

Phone Number: _____

Reviewed by Anesthesia: _____ Date: _____



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Please complete form and fax to the Pre-Admission Testing Department at (937) 866-7062

Surgeon: _____ Anesthesia: _____
Today's Date: _____ Date of Surgery: _____
Patient Name: _____ Patient Date of Birth: _____
Procedure: _____

BLOOD THINNERS:

Patient MAY MAY NOT discontinue his/her aspirin _____ days prior to his/her scheduled surgery with the Dayton Eye Surgery Center.

Patient May May Not discontinue his/her blood thinner(s) _____ days prior to his/her scheduled surgery with the Dayton Eye Surgery Center. ****List prescribed blood thinners below****

Prescribed Blood Thinners: _____

Physician Signature

Date

Physician Printed Name

GLP-1 AGONIST:

Does the patient take a GLP-1 Agonist for diabetes? Yes No Daily Weekly

Does the patient take a GLP-1 Agonist for weight loss? Yes No Daily Weekly

Based on ASA guidelines, DESC providers require GLP-1 Agonist patients to stop taking the medication prior to surgery. Weekly doses should stop **one** week prior to surgery. Daily doses should stop **24 hours** prior to surgery.

Patient MAY MAY NOT discontinue his/her GLP-1 Agonist _____ days prior to his/her scheduled surgery with the Dayton Eye Surgery Center. ****List prescribed GLP-1 Agonist(s) below****

Prescribed GLP-1 Agonist: _____

Physician Signature

Date

Physician Printed Name